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Birthplace in Australia: Processes and interactions during the intrapartum transfer of women from planned homebirth to hospital

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ABSTRACT

Objective: the aim of the study was to explore the views and experiences of women, midwives and obstetricians on the intrapartum transfer of women from planned homebirth to hospital in Australia.
Design: a Constructivist Grounded Theory approach was taken, to conceptualise the social interactions and processes grounded in the data.
Setting: urban and regional areas in four states of south-eastern Australia.
Participants: semi-structured qualitative interviews were conducted with 36 women, midwives and obstetricians who had experienced an intrapartum homebirth transfer within three years prior to the interview. Interviews were audio recorded and transcribed verbatim.
Findings: women who were transferred to hospital from a planned homebirth made physical and psychological journeys out of their comfort zone, as they faced the uncertainty of changing expectations for their birth. The trusting relationship between a woman and her homebirth midwife was crucial to women's sense of safety and well-being in hospital.

Midwives and obstetricians, when congregating in the hospital birthing rooms of transferred women, also felt out of their comfort zones. This was due to the challenges of converging with others who possessed conflicting paradigms of safety and risk in birth that were at odds with their own, and adapting to different routines, roles and responsibilities. These differences were derived from diverse professional, social and personal influences and often manifested in stereotyping behaviours and 'us and them' dynamics. When midwife-woman partnerships were respected as an inclusive part of women's care, collaboration ensued, conflict was ameliorated, and smooth transfers could be celebrated as successes of the maternity care system.
Key conclusions: supporting woman centred care in homebirth transfers means acknowledging the social challenges of collaborating in the unique context of a transferred woman's hospital birthing room. Understanding the power of the midwife-woman partnership, and its value to the health and well-being of each woman and her baby, is key to facilitating a successful transfer.
Implications for practice: the midwife-woman partnership played a central role in providing the necessary support and advocacy for women transferred out of their comfort zone. When midwives worked together in an integrated system to provide the necessary care and support for women who were transferred, greater levels of collaboration emerged and women's perceptions of their quality of care was high. In practice, this meant health professionals respecting each other's roles, responsibilities and expertise, and ameliorating 'us and them' dynamics.

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Introduction

Evidence supports the safety of planned homebirth for women with low risk pregnancies, in the presence of professional midwives who have established collaborative arrangements for medical consultation, referral and transfer (Catling-Paull et al., 2013; de Jonge et al., 2009; de Jonge et al., 2013; Hutton et al., 2016; Keirse, 2014). Although one study reported a small increase in the absolute risk of outcomes for the babies of women having their first baby at home (Brocklehurst et al., 2011), a larger study by de Jonge et al. (2015) did not find any differences by parity in serious adverse neonatal outcomes. When transfer to hospital from a planned homebirth (if required) is not handled smoothly, safety and well-being may be compromised for the women and babies involved (Davis-Floyd, 2003; Vedam et al., 2014).

Relatively few women in Australia choose, or have access to, planned homebirth. In 2013, only 0.3% of all births in Australia occurred at home (Australian Institute of Health and Welfare 2015). The identification of the optimal setting for birth with access to medical backup is important, so women can make informed choices around place of birth. Regardless of biomedical opposition to homebirth on the grounds of safety, some women will always choose to birth at home (Catling-Paull et al., 2011).

Most intrapartum transfers from planned homebirths to hospital are non-urgent. The most common indication is delayed progress in labour (Amelink-Verburg et al., 2008; Anderson and Murphy, 1995; Cheyney et al., 2014a; Davies et al., 1996; Lindgren et al., 2008; Murphy and Fullerton, 1998; Rowe et al., 2013; Tyson, 1991). Other less common indications include a request by the woman for pharmacological pain management (Amelink-Verburg et al., 2008; Cheyney et al., 2014a) or the unavailability of her homebirth midwife (Lindgren et al., 2008). Small numbers of women are transferred due to emergencies (Amelink-Verburg et al., 2008; Anderson and Murphy, 1995; Davies et al., 1996; Durand, 1992; Lindgren et al., 2008; Murphy and Fullerton, 1998; Rowe et al., 2014; Tyson, 1991).

International studies demonstrate a trend for larger proportions of primiparous women to be transferred than multiparous women (Blix et al., 2012; Blix et al., 2014; Blix et al., 2016; Brocklehurst et al., 2011; Tyson, 1991; Wiegers et al., 1998). Much is known about rates of transfer but literature on the experiences of the women and caregivers involved is limited.

Maternity services in Australia

Most women in Australia give birth in private or public hospital settings. In the public system, women experiencing healthy pregnancies are primarily cared for by midwives and women experiencing complications are primarily cared for by obstetricians. In the private system, women are primarily cared for by private obstetricians. Midwifery education in Australia occurs in university settings and must meet national accreditation standards. The current pathways to midwifery registration include a three-year Bachelor of Midwifery degree, four-year dual degree (Bachelor of Nursing/Bachelor of Midwifery), or a twelve to eighteen-month post-graduate diploma, for which nursing registration is a pre-requisite (Gray et al., 2016). All midwives are registered to practise across the full continuum of childbearing in hospitals, birth centres or at home. The majority work in hospitals only (Australian Government, 2017), and therefore would work in the homebirth context only when receiving a woman transferred in to hospital. There are only a few hospitals offering practising rights to privately practising midwives.

Women can access homebirth in Australia in two ways. Publicly funded homebirths have emerged as a model of maternity care in Australia with most of the 15 services in place at the time of writing being established in the past decade (Catling-Paull et al., 2011; Catling-Paull et al., 2012; Catling-Paull et al., 2013; McMurtrie et al., 2009). Publicly funded homebirth services in Australia are available to women living within a 30-minute drive from the public hospital to which they are attached. An evaluation of the publicly funded homebirth programs in Australia showed a high normal vaginal birth rate (90.3%), a high intact perineum rate (56%), a low caesarean section rate (5.4%) and a transfer rate of 17.4% (Catling-Paull et al., 2013).

Women can also access homebirth in Australia by engaging the services of a self-employed privately practising midwife. Privately practising midwives provide antenatal and postnatal care in the community and may also offer homebirth care and/or birth support in hospital. Many are Medicare-eligible, which means that women they care for can receive government rebates for the cost of their antenatal and postpartum care. However, due to the lack of indemnity insurance available to privately practising midwives for intrapartum care in the home, women cannot obtain rebates for intrapartum services at home, making the cost of engaging a privately practising midwife financially prohibitive for some women.

Our metasynthesis of the literature on women's experiences of transfer from planned homebirth is published elsewhere (Fox et al., 2014). The literature on caregivers' experiences of homebirth transfer demonstrates that interactions between different caregivers may involve conflicting paradigms of childbearing. This may function as an opportunity to develop and strengthen connections between them, or it may serve to consolidate discord, potentially threatening women's safety and well-being (Cheyney and Everson, 2009; McLachlan et al., 2016; Vedam et al., 2012, 2014). The presence of conflict between homebirth midwives and hospital staff may impact upon the ability of a homebirth midwife to provide continuity of carer during a transfer. Her access to the hospital may depend upon both her credentials and her relationships with hospital staff (Dahlen, 2012; Foley and Faircloth, 2003; McCourt et al., 2012; Vedam et al., 2014). The significance of this is that the ability of the homebirth midwife to provide continuity of care throughout the transfer and into the hospital setting is important, both to women (Fox et al., 2014) and to homebirth midwives (Ball et al., 2016; Wilyman-Bugter and Lackey, 2013).

The aim of this study was to explore the processes and interactions that occur during transfer from the perspectives of women, midwives and obstetricians involved in the intrapartum transfer of a woman from a planned homebirth to hospital.

Methods

Constructivist grounded theory was the approach used for this study, because it emphasises the conceptualisation of social interactions and processes involved in human experiences and formulates theory grounded in the data (Charmaz, 2014; Dey, 2004; Hall et al., 2013). The constructivist approach to grounded theory enabled the exploration of views and experiences of women and their caregivers, as well as the processes of interaction and the contexts and environments in which they occur. The analysis spans across individual people and single events to reveal an analysis of the interactions that occur between individuals and the processes that brought about and resulted from events, and the relationships between those interactions and those processes (Charmaz, 2011).

Thirty-six semi-structured interviews were conducted face-to-face or by phone with women, midwives and obstetricians in 2014 and 2015. The interviews were conducted with the first author, herself a midwife, in participants' homes or workplaces. The interviews varied in length from 30 minutes to 2 hours. Data were audio recorded and transcribed verbatim. Field notes were taken, to describe the setting and context of the interview and to make note of significant non-verbal actions and interactions.

Grounded theory methodology involves two phases of sampling, namely initial sampling and theoretical sampling. The initial sample was 10 women and 20 caregivers. Due to the sample including different groups of midwives (midwives from private, public and hospital settings), who offered rich and complex data, theoretical saturation